City of Burlington / 2016 CDBG Application Form

Project Name: Complex Case Management for At-Risk Seniors

Project Location / Address: Burlington Vermont

Applicant Organization / Agency: Champlain Valley Agency on Aging

Mailing Address: 76 Pearl Street, Suite 201, Essex Junction, Vermont 05452

Physical Address: Same as above

Contact: Catherine Collins Title: Director of Case Management Phone #: 802-865-0360

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EIN #: 22-2474636 DUNS #: 034409102

CDBG Funding Request: $20,000

Check ONE: _____ **1 year** (Equal Access, Health, Development Projects) **_X_ 2 years** (Housing, Homeless, Hunger)

1. Type of Organization

____ Local Government
____ For-Profit Organization
____ Faith-Based Organization
_X_ Non-Profit Organization (please provide copy of your IRS 501(c)(3) tax exemption letter)
____ Institution of Higher Education

2. Conflict of Interest: **_X_** Please complete and sign attached form.

3. List of Board of Directors: **_X_** Please attach.

Certification

To the best of my knowledge and belief, data in this proposal are true and correct.

I have been duly authorized to apply for this funding on behalf of this agency.

I understand that this grant funding is conditioned upon compliance with federal CDBG regulations.

I further certify that no contracts have been awarded, funds committed or construction begun on the proposed program, and that none will be prior to issuance of a Release of Funds by the Program Administrator. In addition, this project is ready to proceed as of July 1, 2016.

_____ _____
Signature of Authorized Official Name of Authorized Official

_____ _____
Title Date

(Refer to NOFA for required information for each question.)

I. Demonstrated Need

1. What is the need/opportunity being addressed by this program/project and how does that contribute to CDBG's national objectives?

This program provides assistance to seniors with low to moderate incomes, living in Burlington, who need support in order to access services, programs and benefits that can help them remain housed and afford the costs associated with housing and obtaining adequate nutrition. An estimated 5% of the clients that are seen by CVAA case managers have issues related to hoarding, homelessness, eviction and basic lack of self-care. We identify most of these individuals as self-neglect. The project will provide individuals at risk of losing their housing, precariously housed or already homeless, with case management services to address the reasons for the unstable housing situation, collaborate with service providers, mental health agencies, landlords and housing authorities to find solutions and assist the individuals with access to services and programs that will help them to afford and maintain their living situation.

II. Program/Project Design

1. Describe the program/project activities. [UWCC]

CVAA will provide Complex Care Case Management services to individuals identified as self-neglect due to the inability to adequately provide for their own basic needs including shelter, heat, food and medical attention. The complex care case management will be provided to individuals who are at risk of losing their housing due to behaviors, hoarding, squalor or severe medical conditions that prevent them from adequately maintaining their home or hygiene. This case management will also be provided to homeless individuals who, by virtue of severe chronic medical conditions or dementia, cannot be served by Burlington homeless shelters and who refuse to work with mental health providers. The case manager will assess the needs of the individuals; work on developing a trusting relationship in order to address the risk issues; collaborate with other providers, housing inspectors and landlords; make referrals for services as the individual will allow; assess for eligibility for programs and services and refer to a CVAA Wellness Benefits coordinator for an assessment of medications when the need is indicated.

2. Why the program/project is designed the way it is? Explain why the program activities are the right strategies to use to achieve the intended outcomes. [UWCC]

CVAA receives approximately 260 calls and referrals each year from Adult Protective services, service providers, SASH, police, concerned neighbors, family members and landlords for individuals who are identified as self-neglecting; 20 calls/referrals for individuals who are homeless or at risk of losing their housing and 800 calls/referrals from individuals who want to explore options for more affordable housing or programs that can help them pay food, utility and shelter expenses. CVAA employs case managers who work with people to identify their needs and goals and access services. The case managers have large caseloads which allow them limited time to spend with each individual. The most at-risk, vulnerable clients need more one-on-one time in order to fully address the issues that are putting them at risk. For that reason CVAA has hired two complex care case managers to serve our 4 county catchment areas. The complex care case managers have a smaller caseload that allows them to spend more time focused on the needs of the most vulnerable seniors.

3. How will this program/project contribute to the City's anti-poverty strategy?

As with Burlington's anti-poverty strategy, our program strives to meet the basic needs of seniors and stabilize living situations, "including access to and retention of affordable housing" and finding access to support services for the at-risk individual. CVAA's mission and goals coincide with some of the city's 2013 Consolidated Plan strategies including Housing Special Needs, Providing Public Services to At Risk Populations and Protecting the Vulnerable. CVAA serves individuals 60 years of age and older with a priority of meeting the needs of the most vulnerable and at risk adults. CVAA is responsible for receiving and responding to all referrals for seniors identified as self-neglect especially those individuals with few informal supports and at risk of exploitation by others. We provide assessment,

options counseling, person-centered planning, benefits counseling, service coordination and monitoring.

4. **How do you use community and/or participant input in planning the program design and activities? [UWCC]**
   Our program is designed around the needs of the seniors who call or are referred to CVAA for assistance. The program design is also defined by the case management and options counseling standards set by the state of Vermont Department of Aging and Independent Living (DAIL) and the federal Administration on Community Living (ACL). Our recent re-structuring of the CVAA case management program resulted from a need to separate the difficult, hard to resolve, time intensive client issues from the large caseloads in order to provide more time and ability to elicit positive outcomes.

III. Proposed Outcomes

1. **What are the intended outcomes for this project/program? How are people meant to be better off as a result of participating? [UWCC]**
   1. Eviction of self-neglecting individuals is prevented or delayed due to intervention by a Complex Care Case Manager.
   2. Homeless, hard to house individual's access safe housing.
   3. Individuals are assisted to access services that help to maintain housing.
   4. Individuals access benefits and services that help them to access food and improve nutrition.
   5. Individuals have decreased risk as a result of intervention by Complex Care Case Manager.
2. **List your goals/objectives, activities to implement and expected outcomes (# of units, # of individuals, etc.)**

Goal	Activity	Outcome
Prevent eviction of self-neglecting senior	Assessment, intervention, collaboration with housing/landlord; service coordination	5 at-risk seniors are able to prevent eviction
Assist Homeless seniors to access safe housing	Intervention, collaboration with service providers, coordination with mental health providers and housing managers, Advocacy	2 Homeless seniors are housed and can maintain their housing
Housekeeping/Personal care services are in place to assure that housing can be maintained	Complete assessments, apply for in-home services, find funding and providers to clean and provide personal care	10 self-neglecting individuals receive the personal care and homemaking assistance to provide home upkeep
Provide assistance to access food/nutrition benefits and services	Assess for eligibility for public benefits and services to prevent hunger. Submit applications and referrals	20 individuals apply for and receive 3SquaresVermont benefits 10 individuals receive Meals on Wheels
Self-Neglect Risk factors are reduced	Self-Neglect Risk assessment is conducted by Complex Care Case Manager and repeated twice a year	10 individuals have reduced risk assessment scores as a result of CCCM intervention

IV. Impact / Evaluation

1. **How do you assess whether/how program participants are better off? Describe how you assess project/program outcomes; your description should include: what type of data, the method/tool for collecting the data, from whom you collect data, and when it is collected. [UWCC]**

Our typical process for determining whether or not a program participant is better off after receiving services is to send out surveys that ask whether or not the assistance provided has met the needs of the individual and whether or not the assistance provided has improved quality of life. With the population that we are proposing to work with for this project, providing surveys may be difficult as many of the

individuals will have cognitive functioning that may not make it possible for them to participate in a survey. When possible we will survey these individuals. We will also be conducting risk assessments that will elicit a score based on the severity of the risk factors and will repeat them every six months. As the case management interventions are successful, we anticipate the scores will be lower when there have been successes in meeting goals. The Complex Care Case Manager will set goals with anf for the individual and will track the outcomes as they are met.

2. **How successful has the project/program been during the most recent reporting year for your CDBG project? Report the number of beneficiaries you intended to serve with which activities (as noted in your last Attachment A) and your final outcomes (as noted on your Attachment C) from June 2015 (or June 2014). For non-CDBG participants – just report on your achievements from the previous year.**

This is a new project. We hired two complex care case managers in July and they have been out in the field for 3 months. They are both licensed social workers with backgrounds in mental health. We also have an options counseling case manager who provides ongoing service coordination and monitoring for seniors in Burlington and a wellness benefits counselor who helps individuals apply for public benefits, housing and provides Home Meds, medication reconciliation assessments. Since September the complex care case managers have served 18 high risk, vulnerable seniors of whom 13 have been at risk of losing housing due to squalor, hoarding, non-payment of rent and other bills mostly due to mental illness, dementia, substance abuse and traumatic brain injury. The other 5 are homeless and hard to house due to dementia, criminal background, resistance to services and health issues.

The outcomes from our last reporting period 7/1/14 to 12/31/14 included:
156 Burlington seniors assisted with health care issues
62 Burlington seniors assisted with applications and issues related to public benefit programs
10 Burlington seniors were referred to Eldercare clinicians
3 Homeless individuals received case management assistance
10 Burlington seniors were identified as self-neglect and received case management
60 seniors received Options Counseling services
92% of Burlington seniors reported that the assistance they received helped them to remain in their homes.

3. **How does this data reflect beneficial outcomes of this project/program? Has this impacted your program planning at all? [UWCC]**

The data demonstrates that the work that we do is successful and that participants are satisfied with our services and that they are able to have some stability in their lives because we help them meet their needs. In a recent survey 86% of respondents report that the assistance they received has improved their quality of life. With our new proposed project we intend to track the impact of intensive case management for the most vulnerable seniors when the caseload is small enough to allow for more time to devote to finding solutions that will have long-term impact and not just bandage solutions to avert immediate crises.

V. Experience / Organizational Capacity

1. **What is your agency's mission, and how do the proposed activities fit with your mission?**

CVAA's mission is to help seniors age with independence and dignity by providing information, services, education, support and advocacy to seniors and caregivers. We serve all individuals 60 years of age and older, regardless of income who request our services. We also serve individuals who are referred for our services because they are vulnerable and at risk and are not being served by other agencies or organizations.

2. **Please describe any indications of program quality, such as staff qualifications and/or training, adherence to best practices or standards, feedback from other programs or organizations you partner with, etc.**

CVAA employs 22 case managers and 3 Wellness Benefits Counselors for our 4 county area. All of our case managers have at least a bachelor's degree and average experience of about 11 years in the human services field. Three of the case managers are licensed social workers including the two complex care case

managers. New staff receive a minimum of 50 hours of training in the first year of employment and all employees receive a minimum of 20 hours of training each year. Within the next year all of our case management staff will receive training and national certification as Person-Centered Counselors for Options Counseling.

3. What steps has your organization/board taken in the past year to become more culturally competent?

CVAA has provided cultural competency training to our staff each year. In the past year we provided training to our staff on Cultural and Linguistic Competency presented by Maria Mercedes Avila, PhD. We have also hired a full time Refugee case manager who serves the Bhutanese population in Burlington and Winooski and is herself Bhutanese. We applied for and received a grant to provide a case management assistant to the Refugee case manager and to the Community meals programs provided in the refugee community. As part of the grant the UVM Connecting Cultures program will provide mental health assessment and counseling for 8 Bhutanese refugees in the Burlington area.

4. Have you received Federal or State grant funds in the past three years? _X__Yes ___No

5. Were the activities funded by these sources successfully completed? _X__Yes ___No ___N/A
If No, please explain:

VI. Proposed Low & Moderate Income Beneficiaries / Commitment to Diversity

1. Will the program target a specific (solely) group of people? If so, check <u>ONE</u> below:

____ Abused Children	__X__ Elderly (62 years +)	____ People with AIDS
____ Battered Spouses	____ Homeless Persons	____ Illiterate Adults
____ People with Severe Disabilities		

2. For your proposed project, please estimate how the <u>Burlington residents</u> will break out into the following income categories during the total grant period. Use the Income Table at https://www.burlingtonvt.gov/CEDO/2015-HUD-Income-Limits

Service / Activity	Unduplicated Total # of Burlington HH / Persons to be Served	# Extremely Low-Income	# Low-Income	# Moderate-Income	# Above Moderate-Income
Intensive Complex Care Case Management/Food & Nutrition	**40**	**4**	**28**	**6**	**2**

3. a. Who is the project/program designed to benefit? Describe the project/program's target population, citing (if relevant) specific age, gender, income, community/location or other characteristic of the people this program is intended to serve. [UWCC]

The program is targeting seniors who are identified as vulnerable/self-neglect, homeless, precariously housed or at risk of losing housing including hoarders, individuals with dementia, mental illness and chronic medical conditions who are unable or unwilling to adequately manage their basic needs for shelter, heat, nutrition and health care.

b. How do you select and reach your target population?

We receive referrals from service providers, Adult Protective Services, COTS, Burlington Shelter, BHA, landlords, SASH, family members, the clients themselves. This population is often reluctant to accept services. The CCCM receives the referral and meets with the individual in the home, or in a safe, neutral setting with a goal of developing a trusting working relationship. The CCCM tries to meet with the individuals on a weekly basis to work on the issues that are preventing them to maintain a safe living situation.

4. **Describe the steps you take to make the project/program accessible, inclusive and culturally appropriate for the target population. [UWCC]**
   Services are provided in the home or other environment the senior chooses. Family members or other supports are encouraged to participate in assessment and planning if the senior is willing. When there are cultural or language barriers we collaborate with AALV, Refugee Resettlement, Connecting cultures and language line for interpreters and support workers. We also currently employ an Elder Refugee Case Manager who works specifically with the Bhutanese population. Our CVAA brochures are printed in 8 languages that are common for the local refugee/new American populations.

VII. Budget / Financial Feasibility

1. **Budget Narrative: Provide a clear description of what you will do with CDBG's investment in the program. How will you spend the money? Give specific details. [UWCC]**

2. **If you plan to pay for staff with CDBG funding, describe what they do in relation to the specific service(s) / activity(ies) in your Project/Program Design.**

Specific Service / Activity	Position/Title	Work Related to CDBG-Funded Activity	# of Hours per Week spent on this Specific Service / Activity	% of Hours per Week spent on this Specific Service / Activity to be paid with CDBG
Complex Care Case Management for At-Risk, Homeless, precariously housed seniors	**Complex Care Case Manager**	**Risk Assessment, case management, person-centered planning**	**40**	**17%**

3. **Program/Project Budget**

Line Item	CDBG Funds	Other	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$

4. Funding Sources	Project		Agency	
	Current	Projected	Current	Projected
CDBG	$	$	$	$
State (specify)				
Federal (specify)				
United Way				
Private (specify)				
Program Income				
Other (specify)				
Total	$	$	$	$

5. Of the total project cost, what percentage will be financed with CDBG?

$**_____ ÷ **$_____ = _____**%**
CDBG Funding | Total Program/Project Costs | Percentage

6. Of the total project cost, what would be the total cost per person?

$**_____ ÷ _____ = **$_____
Total Program/Project Cost | # Proposed Beneficiaries | Cost Per Person

7. Why should CDBG resources, as opposed to other sources of funding, be used for this project?

8. **Describe your use of community resources, including volunteers. Include any resources not listed in your budget. Will CDBG be used to leverage other resources?**

9. **If your organization has experienced any significant changes in funding levels during the past year, please explain.**

10. **What cost-cutting measures has your organization implemented?**

VIII. Collaboration/Efficiency

1. **Share specific examples of how your agency collaborates with other programs or agencies to address the needs of the people you serve. Do not just list organizations with whom you collaborate. [UWCC]**

We work very closely with the Department of Aging and Independent Living and DCF to identify, assess and implement in-home services to help individuals receive personal care at home to avoid nursing home placement. We have a strong collaborative relationship with the VNA; they often will make referrals for clients that need ongoing assistance when they can no longer serve them due to Medicare/Medicaid payment rules. VNA RN's and social workers and CVAA case managers have close ongoing contact to avoid duplication of effort when both are involved with the same client. We often work together to make sure the needs of at risk clients are met. We work collaboratively with the Community Health Teams when a client's health needs are affected by conditions in the home or lack of services, nutrition or housing. CVAA case managers are members of the SASH partnership in senior housing sites and collaborate with the SASH coordinators and wellness nurse to share the responsibility for keeping seniors safe and healthy at home. We also work closely with Howard Services and share clients in common when an individual with severe mental health issues is seen by a CRT case manager but needs to access public benefits and services for seniors. We also contract with Howard to provide an Eldercare clinician to provide in home counseling for seniors with depression, grief and anxiety issues.

2. **Describe your agency's efforts at becoming more efficient in achieving your outcomes or managing your project/program.**

The Area Agencies on Aging around the state have been working with the Department of Aging and Independent Living to identify outcomes and develop Results Based Accountability standards around our services so that we can collect data to help us demonstrate the work that we do. We currently complete Risk Assessments on the self-neglect clients that we see and repeat them on a 6 month basis to try to capture improvements in the living situation of the at-risk clients that will demonstrate the impact of case management on the self-neglect individuals. We survey the clients for whom we provide case management, options counseling and Information and Assistance services. The surveys request feedback about the services that were provided, in particular we ask if the services provided helped the individual to remain at home; if the services helped the individual to better afford their monthly living expenses; improved quality of life; provided the information and support needed to make long term care decisions; and helped the individual to access the services and supports to meet their needs. We continue to work on developing criteria to demonstrate the positive outcomes we are able to help our clients achieve.

3. What other agencies provide similar services or programs? [UWCC]

CVAA is the only agency serving seniors that provides case management services to seniors regardless of payment source. When the VNA is unable to serve seniors because of restrictions related to Medicare or Medicaid, they refer to CVAA for clients who need services that they are unable to provide. We sit on the SASH teams and provide the case management services for seniors who have high needs and need ongoing or intensive case management. We receive all of the referrals that are made to Adult Protective Services for individuals identified as self-neglect. We provide assessment of eligibility for all programs and services available to seniors in the region and state and help people apply for those programs. We provide service coordination and monitoring of the services and provide intensive training in all services and public benefits that are available for seniors. We are the only agency that has the training, supervision and depth of information for seniors. Most of the other agencies serving seniors refer to CVAA for ongoing case management and information and referral.

IX. Sustainability

1. How will this project have a long-term benefit to the City of Burlington? If this project ends, will that benefit continue?

Complex Case Management for at-risk seniors is a valuable resource for the City of Burlington. Our program is a referral source to the city when there are older individuals that have been identified at risk and in need of care or services. We currently work collaboratively with most of the organizations serving Burlington residents including the housing authorities and the Hoarding Task force, and can provide senior's focused information and assistance that is not offered by any other organization in the community. We often work as part of a team to address the needs of frail, low income seniors. If the project ends we will continue to serve the seniors in Burlington as we would serve all seniors. In the future we may need to further prioritize what we do and how we do it which may mean waiting lists. But we are committed to serving the people who have the greatest needs.

2. If CDBG funding ends, will the project be able to continue?

CVAA has been implementing many changes within the organization to assure that we are not only meeting the current needs of the seniors in our area, but looking at the changing environment where funding streams are not increasing and the demands for services are growing. As the aging population grows so will the needs for services so we are investigating other alternatives for funding including the health care system. We have cut services over the years that we have felt were low priorities but the most vulnerable seniors will always be a high priority for our agency and we will find a way to continue serving this population if the project ends.